Division of Health Care Facilities

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	TN1936	A. BUILDING: **01 - MAIN BUILDING** B. WING _____	R **10/14/2019**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIFE CARE CENTER OF HICKORY WOODS	**4200 MURFREESBORO PIKE ANTIOCH, TN 37013**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
{N 000}	Initial Comments A Life Safety revisit survey was conducted on 10/14/2019 for the previous deficiencies cited on 09/09/2019. The deficiencies have been corrected, and no new non compliance was found. The facility is in compliance with all regulations surveyed.	{N 000}		

Division of Health Care Facilities

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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N 000	Initial Comments Stories: 1 Construction Type: NFPA, III (211); IBC, III protected Plans available on site Constructed: 2011 Sprinklered: Yes Certified beds: 124 A Life Safety Code Survey was conducted by the State of Tennessee Department of Health Division of Health Licensure and Regulations Office of Health Care Facilities on 09/09/2019. During this Life Safety Survey, Life Care Center of Hickory Woods was found not in substantial compliance with the requirements of the Tennessee Rules and Regulations 1200-08-06, Standards for Nursing Homes, and National Fire Protection Association (NFPA) 101 Life Safety (2012 Edition). The requirements at 1200-080-06, Standards for Nursing Homes is NOT MET as evidenced by:	N 000	N - 831 **A. What corrective action(s) will be accomplished for those residents found to have been affected:** On 9/12/2019 all items being stored in the service cooridor were removed. **B. How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?** Beginning on 9/12/2019 Maintenance Director educated all dietary, maintenance, housekeeping and central supply associates on not storing any items in the service corridor. **C. What measures will be put into place or what systematic changes will you make to ensure that the deficient practice will not recur?** 1) Beginning on 9/12/2019 Maintenance Director educated all dietary, maintenance, housekeeping and central supply associates on not storing any items in the service corridor. 2) Maintenance department will audit service cooridor daily times three months to ensure no items are permanently stored.	
N 831	1200-8-6-.08 (1) Building Standards (1) A nursing home shall construct, arrange, and maintain the condition of the physical plant and the overall nursing home environment in such a manner that the safety and well-being of the residents are assured. This Rule is not met as evidenced by: Based on observation, the facility failed to maintain the ohyical plant and overall enviroment. The findings included:	N 831	**D. How will the corrective action(s) be monitored to ensure the deficient practice will not recur; i.e., what quality assurance program will be put into place.** Results of the service cooridor audit will be reported and reviewed by the PI / QA Committee which includes the Executive Director, Medical Director, Director of Nursing, Director of Marketing, Pharmacist, Director of Admissions, Director of Social Service, Rehab Services Manager, Director of Activities, Director of Environmental Services, Dietary Manager, Director Maintenance, Business Office Manager, Health Information Manager, and Staff Development Coordinator in Monthly QA meeting and corrections made as needed.	9/30/2019

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N 831	Continued From page 1 Observaton on 09/09/2019 at 10:55 AM, revealed storage throughout the service corridor including mattresses, cases of paper, wheeled carts, and tables. NFPA 1, 14.3.3 (2012 Edition) The Maintenance Director was present when these deficiencies were identified and the Administrator acknowledged these deficiencies during the exit conference on 09/09/2019.	N 831	N - 1410 **A. What corrective action(s) will be accomplished for those residents found to have been affected:** On 9/9/2019 it was noted that the disaster drills were conducted prior to March 2018 and 2019, but evaluation was not written. **B. How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?**	
N1410	1200-8-6-.14(2)(a)5.(ii) Disaster Preparedness (2) Physical Facility and Community Emergency Plans. (a) Physical Facility (Internal Situations). 5. Each of the following disaster preparedness plans shall be conducted annually prior to the month listed in the plan. Drills are for the purpose of educating staff, resource determination, testing personnel safety provisions and communications with other facilities and community agencies. Records which document and evaluate these drills must be maintained for at least three (3) years. (ii) External disaster procedures plan (for tornado, flood, earthquake), to be exercised prior to March, shall include: (I) Staff duties by department and job assignment; and, (II) Evacuation procedures. This Rule is not met as evidenced by: Based on document review, the facility failed to	N1410	On 9/16/2019 the Executive Director educated the maintenance department on completing an evaluation after disaster drills are conducted. **C. What measures will be put into place or what systematic changes will you make to ensure that the deficient practice will not recur?** Executive Director will audit disaster drill evaluations monthly times 3 months to ensure completed. **D. How will the corrective action(s) be monitored to ensure the deficient practice will not recur; i.e., what quality assurance program will be put into place.** Results of disaster drill evaluation audits will be reported and reviewed by the PI / QA Committee which includes the Executive Director, Medical Director, Director of Nursing, Director of Marketing, Pharmacist, Director of Admissions, Director of Social Service, Rehab Services Manager, Director of Activities, Director of Environmental Services, Dietary Manager, Director Maintenance, Business Office Manager, Health Information Manager, and Staff Development Coordinator in Monthly QA meeting and corrections made as needed.	9/30/2019

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N1410	Continued From page 2 exercise and evaluate the disaster plans. The findings included: Document review on 09/09/2019 at 9:26 AM, the facility could not provide documentation and evaluation of drills for the following disaster plans conduct prior to March of 2018 and 2019: a. earthquake. b. flood. The Maintenance Director was present when these deficiencies were identified and the Administrator acknowledged these deficiencies during the exit conference on 09/09/2019.	N1410	N - 1411 **A. What corrective action(s) will be accomplished for those residents found to have been affected:** On 9/26/2019 facility conducted a bomb threat drill and evaluation to the drill. **B. How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?** On 9/16/2019 Executive Director educated maintenance department on conducting a bomb threat drill annually. **C. What measures will be put into place or what systematic changes will you make to ensure that the deficient practice will not recur?**	
N1411	1200-8-6-.14(2)(a)5.(iii) Disaster Preparedness (2) Physical Facility and Community Emergency Plans. (a) Physical Facility (Internal Situations). 5. Each of the following disaster preparedness plans shall be conducted annually prior to the month listed in the plan. Drills are for the purpose of educating staff, resource determination, testing personnel safety provisions and communications with other facilities and community agencies. Records which document and evaluate these drills must be maintained for at least three (3) years. (iii) Bomb Threat Procedures Plan, to be exercised at any time during the year: (I) Staff duties by department and job assignment; and,	N1411	On 9/26/2019 Maintenance Director added bomb threat drill to TELS tracking system to ensure drill is conducted annually. **D. How will the corrective action(s) be monitored to ensure the deficient practice will not recur; i.e., what quality assurance program will be put into place.** Results of bomb threat disaster drill will be reported and reviewed by the PI / QA Committee which includes the Executive Director, Medical Director, Director of Nursing, Director of Marketing, Pharmacist, Director of Admissions, Director of Social Service, Rehab Services Manager, Director of Activities, Director of Environmental Services, Dietary Manager, Director Maintenance, Business Office Manager, Health Information Manager, and Staff Development Coordinator in Monthly QA meeting and corrections made as needed.	9/30/2019

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N1411	Continued From page 3 (II) Search team, searching the premises. This Rule is not met as evidenced by: Based on document review, the facility failed to exercise and evaluate the disaster plans. The findings included: Document review on 04/02/2019 at 9:26 AM, the facility could not provide documentation and evaluation of a drill for the bomb threat disaster plan conduct during of 2018. The Maintenance Director was present when these deficiencies were identified and the Administrator acknowledged these deficiencies during the exit conference on 09/09/2019.	N1411		